Health History Form
Birth to 5

Date: ________________________**Name:** ________________________________**DOB:** ________________________

Pharmacy: ____

Please **CIRCLE** One

Primary Language in home: English Spanish Other: ____________________________

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Race: White Asian Native Hawaiian / Pacific Islander Black / African American 2 or more races

Current Medications: ____

Allergies: ____

Patient's Past Medical History	**CIRCLE** One		Additional Information (ex: Test / Date / Details)
Prior Testing/Development Test	None	Yes	Test:
Allergies	No	Yes	
History of Chicken Pox	No	Yes	Date:
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU/Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of Injury/Trauma	No	Yes	Details:
Other Medical History	No	Yes	

Family Health History	**CIRCLE** One		Please List Family Member & details below
Bleeding disorder	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Cardiovascular disorder	No	Yes	
Congential heart disease	No	Yes	
Eye disorder	No	Yes	
Ear disorder	No	Yes	
Respiratory disorder	No	Yes	
GI disorder	No	Yes	
Musculoskeletal disorders	No	Yes	
Neurologic disorder	No	Yes	
Psychiatric disorder	No	Yes	
SIDS	No	Yes	
Skin disease	No	Yes	
Other Medical History	No	Yes	

Health History Form
Birth to 5

Birth History	CIRCLE if applies		Additional Information (ex: Date / Details)
Birth Location / Hospital			
Type of Delivery / Complications	Vaginal	Cesarean	
Gestational Age	Full Term		
Birth Complications	None		
Apgar Scores			
Blood Type			
Oxygen at birth	Yes	No	
NICU Stay	Yes	No	
Synagis prophylaxis given in hospital	Yes	No	
Birth weight			
Discharge weight			
Length			
Head circumference			
Hep B given birth	Yes	No	
Mother's pregnancy health	Normal		

Newborn Screening Test	CIRCLE One		
Newborn Hearing Test	Normal	Abnormal	Not Performed
Newborn State Screen (PKU)	Normal	Abnormal	Not Performed
Supplemental State Screen	Normal	Abnormal	Not Performed
Other Newborn Screening test	Normal	Abnormal	Not Performed

Patient's Surgical / Hospitalization History	CIRCLE One		Details
Non-Surgical hospitalizations	None	Yes	
Surgical History	None	Yes	
Ear Surgery	None	Yes	
Nose/Mouth/Throat Surgery	None	Yes	
Respiratory Surgery	None	Yes	
Cardiovascular Surgery	None	Yes	
GI Surgery	None	Yes	
GU Surgery	None	Yes	
Eye Surgery	None	Yes	
Orthopedic Surgery	None	Yes	
Plastic Surgery	None	Yes	
Other Surgery	None	Yes	

Child Social History

CIRCLE all that apply

Parent Information:

Parents together	Father involved	Guardian parents
Lives w/Mother	Mother not involved	Same sex partners
Lives w/Father	Mother involved	Other: ______________________
Father not involved	Mother / Father deceased	

Health History Form
Birth to 5

Child Care: **CIRCLE** all that apply

Name of Daycare: ____

Home w/parents

Private home day care

Sitter to home

Family Day care

Other: ____

Home occupants: (list **ALL**) ____

Parents smokers: (**CIRCLE** One) Yes No Outside Only

Pets:

None	**How many Inside (#)**	**How many Outside (#)**
Dog(s)		
Cat(s)		
Bird(s)		
Reptile(s)		
Rodent(s)		
Fish(s)		
Other: ________________		